STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

In the matter of the Ambulatory Surgical Facilities
Remedial Provider Class Plan Determination
Report pursuant to P.A. 350 of 1980
_____/ No. 01-021-BC

Issued and entered
This _29th_ day of March, 2001
by Commissioner Frank M. Fitzgerald

ORDER DETERMINING GOAL ACHIEVEMENT OF BLUE CROSS BLUE SHIELD OF MICHIGAN REMEDIAL AMBULATORY SURGICAL FACILITY PROVIDER CLASS PLAN

BACKGROUND

On July 6, 1999, the Commissioner issued Order No. 99-117-BC. This order provided written notice to Blue Cross Blue Shield of Michigan (hereafter BCBSM), health care providers and other interested parties of his intent to make a determination with respect to the Ambulatory Surgical Facility (ASF) Provider Class Plan for the calendar years 1996 and 1997. Order No. 99-177-BC also called for persons to submit comments regarding the Plan to the Insurance Bureau (now called the Office of Financial and Insurance Services, or OFIS) in accordance with MCL 550.1505(2). A Notice of Hearing was attached to the Order scheduling a public hearing for Wednesday, August 23, 1999 that gave interested parties a reasonable amount of time to prepare testimony with regard to the ASF Provider Class Plan.

In an Order dated March 30, 2000, the Commissioner determined that the ASF plan had failed the P.A. 350 quality and access goals and required BCBSM to rewrite the plan pursuant to MCL 550.1510. In accordance with MCL 550.1511, BCBSM had six months to redraft the ASF Provider Class Plan. As required by MCL 550.1505(1), BCBSM established and implemented very inclusive procedures for obtaining advice and consultation from providers, subscribers and purchasers in developing this remedial plan. To allow time to conduct 2 large advisory meetings and to circulate draft revisions to the participants, BCBSM requested an extension of 90 days, as allowed by MCL 550.1512, in order to complete the remedial plan.

With the extension, BCBSM's remedial ASF Provider Class Plan was due by December 29, 2000. OFIS received the Plan on December 29, 2000. On January 3, 2001, OFIS sent all interested parties a copy of the remedial provider class plan and accepted written advice and consultation with respect to the remedial plan**,** through January 31,2001, as required by MCL 550.1513(3).

MCL 550.1513(1), requires the Commissioner to take no more than 90 days to examine the plan and determine if the plan submitted by BCBSM on December 29, 2000 substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated in the findings made by the Commissioner in his order of March 30, 2000.

DISCUSSION

BCBSM established the ASF provider class in 1992 and the Commissioner scheduled it for a first review in 1999. As a result of that review, the Commissioner required BCBSM to rewrite the ASF plan to correct the identified deficiencies. This was the first time that a commissioner had ever made such a determination of goal failure. As noted in the determination report, the physician, hospital, subscriber, and purchaser communities all view the role of ASFs from different perspecitives. This lack of consensus continued to be apparent in the testimony received regarding the remedial plan.

The Michigan Health and Hospital Association (MHHA) provided input on BCBSM's ASF plan on behalf of its members. The MHHA recommended that ASFs have a 3-room minimum in urban areas and at least 2 rooms in rural or sole-community areas, using the certificate of need (CON) minimum annual standard of 1,200 procedures per room. MHHA's rationale is that maintaining volumes and room sizes ensure adequate back-up facilities are available, that ASFs are maintaining the volume identified in their original CON request, and that services available elsewhere are not duplicated in the community. The MHHA believes that BCBSM's provider class plan needs to include a standard that does not differentiate between single or multi-specialty or ownership type to eliminate the unwarranted perception that bias exists toward a particular ASF category.

Not surprisingly, physicians have a very different idea of what should be contained in BCBSM's ASF plan. Much of the comments from providers and subscribers expressed concern that BCBSM's remedial plan does not do enough to level the playing field between hospital and physician-owned ASFs. It was felt that BCBSM's ASF remedial plan should be restructured to truly create equity in the marketplace by encouraging competition and the highest quality of care at the fairest price.

Other concerns expressed by ASF providers and the Michigan Ambulatory Surgical Association (MASA) focused on BCBSM's proposed requirement that multi-specialty and single-specialty facilities maintain a minimum number of operating rooms and provide a minimum of 1,200 cases or 1,600 hours per operating room per year. It was also felt by providers that the remedial plan does not provide nonparticipating providers enough transition time to allow physicians to change how they schedule surgeries so that ASFs will be able to meet BCBSM's minimum volume requirements during the first re-certification period.

While the Commissioner acknowledges and considered these comments as well as all other comments received from interested parties, the Commissioner draws his conclusions based on the totality of the information available.

MCL 550.1504(1) requires, in pertinent part, a health corporation to "contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services . . . ." In the Commissioner's March 30, 2000 determination report, although the cost goal was met, BCBSM was found not to have met the quality and access goals in its Ambulatory Surgical Facility Provider Class Plan. However, in the remedial plan filed on December 29, 2000, all three elements were again reviewed to determine whether they met all applicable the statutory requirements.

COST GOAL

The Commissioner found in his determination report of March 30, 2000 that BCBSM's ASF provider class plan achieved this goal during the 2-year period under review. The Commissioner concludes that the rewritten plan will continue to achieve this goal, since the reimbursement methodology is unchanged from the original plan.

In order to meet the cost goal, BCBSM was limited in the rate of increase in total payments per member for ambulatory surgical facility providers to the compound rate of inflation and real economic growth as specified in P.A. 350. The reimbursement arrangements in the original plan yielded a 2-year average increase in costs of 3.4%, which was only 88% of the maximum increase of 3.9% allowed by the cost goal calculation.

Since the reimbursement methodology is unchanged in the remedial plan, it is reasonable to conclude the rewritten plan will also achieve this objective and will keep cost increases below the compound rate of inflation and real economic growth. Also, while the revised evidence of need (EON) standards in the rewritten plan will increase the number of participating facilities, it appears likely

BCBSM will do so in a measured way that will not be counterproductive to containing overall health care costs (see page 35 of the March 30, 2000 determination report).

It is important for BCBSM to provide equitable reimbursement to ASF providers in return for high-quality services that are medically necessary. Both the original and the remedial ASF provider class plans have the same reimbursement for ASFs regardless of their ownership. This is clearly equitable. Also, as noted on page 37 of the determination report, BCBSM is reducing the differential in reimbursements between ASFs and hospital outpatient departments, which increases the equity of the payment between the ASF and the hospital provider class plan.

ACCESS GOAL

The March 30, 2000 determination report found that BCBSM failed to achieve this goal which states "there will be an appropriate number of providers through this state to assure the availability of certificate covered health care services to each subscriber." After review of the remedial plan, the Commissioner concludes that the plan now achieves this goal.

The March determination report identified as the main access deficiencies BCBSM's failure to use reasonable standards in applying its evidence of need (EON) criteria and its failure to apply the EON standards uniformly. BCBSM has substantially overcome these deficiencies in the rewritten plan by completely rewriting the EON standards, called qualification standards in the remedial plan, and by providing for transition periods in the application of these standards for both currently participating and nonparticipating providers that will begin "leveling the playing field" during the current year. Although it is clear from the advice and consultation received by the Commissioner that the new qualification standards are not warmly received by all interested parties, the Commissioner concludes that they are objective and reasonable, they overcome the deficienies identified in the review, and they incorporate many of the recommendations found on pp. 21-22 of the March 2000 determination report.

Also, although some nonparticipating providers advised that the remedial plan does not include enough transition time to allow physicians to change how they schedule surgeries so that ASFs are able to meet BCBSM's minimum volume requirements during the first re-certification period, the Commissioner is satisfied that the transition period will allow enough physician owned ASFs to participate during the first year of the remedial plan to substantially meet the acess goal and objectives.

The other main access deficiency identified in the termination report was a lack of participating facilities in certain areas of the state (determination report, page 11) based on BCBSM's participation rates during 1996 and 1997. Based on data provided by BCBSM participation criteria in the remedial plan, it appears that the likely result of participation rates during the first year of the remedial plan will be as follows:

Region	1996 Total Licensed Providers	1996 Par Rate	1997 Total Licensed Providers	1997 Par Rate	Total Licensed Providers	First Year Remedial Plan Est. Par Rate
1	28	46.4%	30	40.0%	30	30.0%
2	1	00.0%	1	00.0%	1	00.0%
3	4	00.0%	5	20.0%	3	66.7%
4	2	00.0%	4	25.0%	3	33.3%
5	7	14.3%	7	28.6%	7	71.4%
6	5	40.0%	5	40.0%	6	66.7%
7	2	100%	2	100%	2	100%
8	1	00.0%	1	00.0%	1	100%
9	2	00.0%	3	00.0%	3	33.3%
Statewide	53	35.8%	59	35.6%	56	44.6%

In finding that BCBSM failed to achieve the access goal, the determination report cited BCBSM's low participation rate. For the review period, the participation rate was below 36% of all licensed ASFs. BCBSM also provided participation data on a more limited data set that included only ASFs with five areas of surgical care. Even in this limited data set, BCBSM's participation rate was below 50%. (See page 9 of the March 30, 2000 determination report).

The remedial plan substantially overcomes this deficiency and substantially achieves the access goal by increasing the participation rate by 25% in the first year of the remedial plan over the participation rate in the 1996-97 review period. P.A. 350 does not define any particular measure of participation as indicative of adequate access to the certificate covered services available through any provider class. Consequently, achievement of the access goal cannot be determined by attaining any certain participation percentage, unlike the numerical simplicity of the cost goal. However, a significant increase in provider participation is indicative of substantial achievement. In this case, BCBSM increased its participation from only one-third of licensed facilities to nearly one-half of licensed facilities, with much of it concentrated in underserved areas.

In absolute numbers of participating providers, the remedial plan is expected to raise the total number of participating ASFs from a statewide 1996-97 average of

20 during the review period to 25 in the first year of the remedial plan. More importantly, the imbalance between participation with ASFs owned by hospitals and those owned by physicians is significantly narrowed, with the number of physician-owned ASFs expected to increase by 800%, from only 1 (with whom BCBSM only participated because of a court order) during the review period to 8 during the first year of the remedial plan.

To achieve the increase in participation by physician-owned ASFs, the remedial plan uses reasonable standards and applies them consistently so that BCBSM does not deny participation on the basis of ownership of a facility. The standards in the remedial plan no longer allow hospitals to transfer operating rooms to outpatient facilities. This substantially overcomes a deficiency noted in the March, 2000 determination report (see second bullet, page 20).

The requirement that a facility must perform at least 5 surgical categories (out of 11 BCBSM-established categories) has been eliminated. BCBSM will now participate with single-specialty ASFs that otherwise meet its participation requirements.

The revised EON standards in the remedial plan also substantially incorporate the recommendations on pages 21-22 of the March 30, 2000 determination report. The intent of these revised standards is to increase the likelihood that the new provider class plan will meet the access goal, and the Commissioner believes these goals are now met. These revised standards include developing different EON criteria for single-specialty clinics, using a minimum number of procedures per room in computing EON, and eliminating the trading of operating rooms from the EON calculation.

Because of the greater equity in the qualification standards and their application guidelines in the remedial plan, the increase in the number of physician-owned ASFs will be counterbalanced by a slight decrease in the number of hospital-owned ASFs from an average of 19 during the review period to 17 during the first year of the remedial plan.

Although statewide participation rates are a useful measure of access to ASFs, regional participation is an even more important measure of the availability of ASFs throughout the state. The remedial plan achieves significant increases in participation in a number of regions, including the Upper Peninsula and Northern Lower Michigan, as noted on page 11 of the March 31, 2000 determination report. The remedial plan dramatically increased participation rates in rural areas such as these by adopting a lower minimum operating room standard in recognition of the unique needs of rural communities.

QUALITY GOAL

The March, 2000 determination report found that BCBSM failed to meet this goal, which requires that providers will meet and abide by reasonable standards of health care quality. Factors underlying this determination included BCBSM's failure to review or re-certify ASF's compliance with the EON standards, BCBSM's failure to communicate quality standards clearly to providers, and a BCBSM audit process that does not really measure the quality of the facility services provided. After review of the remedial plan, the Commissioner concludes that the plan now achieves this goal.

In the remedial plan, BCBSM sets forth policies intended to assure that all ASFs, whether currently participating or applying for participation, must meet the same qualification standards on an on-going basis. It provides that facilities that fail to meet the standards will not receive or maintain participating status. This substantially overcomes BCBSM's failure to re-certify, as found in the March, 2000 determination report.

None of the public input received made comment on whether the certification period should be 3 years, as suggested in the determination report. Instead, public input focused on BCBSM's proposal that facilities be re-certified on an annual basis as it was felt that BCBSM's policy would result in a revolving door of qualifying facilities and have a negative impact the stability of BCBSM's provider network. Based on the advice received by the Commissioner and his review of the remedial plan, it appears that there is no certainty as to the ideal length for a re-certification period. It is in not in BCBSM's interest to propose a re-certification period that it expects to lead to unstable networks with constant turnover. If annual recertification proves to be too frequent, BCBSM can modify the length of the period to correct any problems.

The remedial plan also contains several new objectives that address the communication deficiencies. These include at least twice yearly meetings with the ambulatory surgery facilities liaison committee to allow providers the opportunity to discuss issues of quality of care, medical necessity, participation standards, etc., and the regular provision of information to all participating providers with regard to change in payable services, billing requirements, etc. The remedial plan no longer relies on BCBSM's audit process as the sole measure of the quality of the services provided. Over the past year, BCBSM has held two meetings with ASFs. Representatives of all licensed ASFs were invited to both of these meetings, as well as the Michigan Health and Hospital Association, the Economic Alliance, and other interested parties. There were approximately 60 invitees to each of these meetings. In one meeting, roughly 35 people attended; in the second meeting, there were approximately 45 attendees.

A new objective in the remedial plan is to assess member satisfaction with ambulatory surgical facility services. It also incorporates most of the recommendations in the determination report for ensuring that the remedial plan meets the quality goal, including the organization of a liaison committee, clear communication of participation criteria, and development of methods to gauge subscribers' preferences.

After an extensive review of the remedial plan and all related documentation, both from BCBSM and from interested parties, the Commissioner notes that perhaps BCBSM may want to revise what provider types may be included in its provider classes.

P.A. 350 vests in BCBSM the services for which it will develop provider class plans. There is no absolute requirement that this ASF provider class plan will be independently presented. A separate surgical provider class plan could contain issues presented in this ASF provider class plan.

The preparation and review of all provider class plans are time-intensive undertakings for everyone involved. Although the issues presented in this plan are important, they can receive appropriate and timely treatment in the future as part of a more comprehensive provider class plan.

The Commissioner strongly encourages BCBSM to consider, in the future, the creation of a provider class plan for all surgical services. Doing so would promote administrative efficiency and better serve the health care needs of Michigan's citizens.

ORDER

Therefore, it is ORDERED that:

1. The ambulatory surgical facilities provider class plan as filed by BCBSM on December 29, 2000 substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner in the March, 2000 determination report. The plan is therefore retained and placed into effect, as provided by MCL 550.1506.

2. Pursuant to MCL 550.1510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of the Commissioner's determination in this matter by certified or registered mail.

3. Appeals may be filed pursuant to MCL 550.1515. Any request for such appeal shall be made within 30 days after receipt of the notice, as given under MCL 550.1513(3).

The commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary, and appropriate.

Frank M. Fitzgerald
Commissioner